



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Christine W. Wan, M.D.

Respondent Name

Service Lloyds Insurance Company

MFDR Tracking Number

M4-16-3365-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

July 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: \$165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel will maintain the requestor is not entitled to reimbursement for CPT Code(s) 99213 and 99080(-73) in dispute based on failure to accurately submit medical billing data in accordance with division rules set forth for a licensed provider."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 20, 2015	Evaluation & Management, established patient (99213) Work Status Report (99080-73)	\$165.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the requirements for submitting medical bills.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – Time Limit for Filing Claim/Bill has Expired.
 - B20 – Srvc partially/fully furnished by another provider.

- Note: “Per Rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care. (Pete lenatsch PA)”
- Note: “Effective 9/1/05, providers have 95 days to submit bills to the insurance carrier for reimbursement. Your bill exceeds this limit. Reimbursement is denied in accordance with Section 408.027 of the Act.”
- B5 – Pymnt Adj/Program guidelines not met or exceeded.
- Note: “Per T.A.C Title 28, Chapter 10, Rule 10.82(i) The network shall credential all doctors & HCPs. A network shall credential each doctor & HCP who is a member of a contracting group.”
- 170 – Denied when performed/billed by this provider
- Note: “Only a licensed physician can determine RTW status and complete the -73 form.”

Issues

Is the insurance carrier’s reason for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code B20 – “Srvc partially/fully furnished by another provider.” 28 Texas Administrative Code §133.20(e)(2) requires that a medical bill must be submitted “in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.” Further, 28 Texas Administrative Code §133.10(f)(1) requires the following information be included:

- (U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider shall enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');
- (V) rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number; ...
- (Z) signature of physician or supplier, the degrees or credentials, and the date (CMS-1500/field 31) is required, but the signature may be represented with a notation that the signature is on file and the typed name of the physician or supplier

Review of the submitted information finds that the health care provider listed in CMS-1500/field 31 is Pete lenatsch, P.A. The progress notes included in the submitted documentation identify Pete lenatsch, P.A. as the rendering health care provider. The division finds that Pete lenatsch is a licensed physician’s assistant with the state of Texas, license number PA05044, NPI 1679608038. Both the license and NPI number for Pete lenatsch were valid at the time of service. The state license number and NPI number listed in CMS-1500/field 24j are both registered to Christine W. Wan, M.D. The insurance carrier’s denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

October 7, 2016
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.